

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **JOHN PELLERITO, M.D.**

4 License No. 14864

5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Case No. MD-10-1255A

**FINDINGS OF FACT, CONCLUSIONS  
OF LA W AND ORDER**

(Letter of Reprimand and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on  
8 June 8, 2011. John Pellerito, M.D. ("Respondent") appeared before the Board for a formal  
9 interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board  
10 voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of  
11 the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of  
14 the practice of allopathic medicine in the State of Arizona.

15 2. Respondent is the holder of license number 14864 for the practice of  
16 allopathic medicine in the State of Arizona.

17 3. The Board initiated case number MD-10-1255A after receiving a complaint  
18 from the patient's mother regarding Respondent's care and treatment of a 27 year-old  
19 female patient ("SM") alleging inappropriate prescribing.

20 4. Respondent began to see SM as a patient in March 2007 for severe chronic  
21 pain of bilateral TMJ that she had experienced since the age of six. SM had co-morbidities  
22 with neck pain, upper back pain, headaches and insomnia.

23 5. According to the Board's medical consultant, Respondent did not obtain  
24 consultations for the work up of SM's complaints regarding neck pain, upper back pain,  
25 insomnia or headaches. The medical consultant also stated that he failed to refer her for

1 physical therapy, neurology, psychiatry, anesthesiology, or other specialties to manage her  
2 pain. According to Respondent's testimony at the formal, hearing however, the patient did  
3 see a TMJ specialist

4 6. SM had a history of opioid abuse and treatment at a drug detox center, yet  
5 Respondent prescribed her methadone and other opioids even after she failed to see a  
6 pain specialist or return to the drug detox center. Finally, Respondent received an x-ray of  
7 SM performed on March 11, 2010 with a diagnosis of "overdose," but failed to document  
8 any discussion of this result with the patient.

9 7. Respondent did not monitor SM for aberrant behavior and side effects of the  
10 medication prescribed. He administered a urine drug screen on only one occasion even  
11 though a pharmacy informed him that she had submitted prescriptions from other  
12 providers for Oxycodone and Percocet.

13 8. In February 2010, a pharmacy questioned the prescription for Restoril to be  
14 given with Methadone. In June 2010, the pharmacy called to change the prescription of  
15 Ciproflaxin and it was changed to Bactrim due to moderate interaction of Ciproflaxin with  
16 Methadone.

17 9. Respondent failed to do X-rays, MRI, EMG/NCS or sleep studies on SM  
18 and did not execute a pain contract with her until February 2009. He also failed to  
19 document a detailed history and physical and establish medical diagnoses during the  
20 course of the treatment.

21 10. At the Formal Interview, Respondent testified that the patient came to him in  
22 pain and appeared to have nowhere else to go. He believed that his job was to try to help  
23 her. He acknowledged that he did not do some of "the objective things" he should have  
24 been doing, but noted that the patient had started to see a psychiatrist and had been  
25 improving.

1           11. During deliberations, Board members expressed concern that Respondent  
2 had previously received an Advisory Letter for inappropriate prescribing practices and that  
3 the potential for serious harm to the patient in this case was substantial..

4           12. The standard of care for prescribing opioids for chronic pain requires a  
5 physician to establish the diagnosis and treatment plan prior to prescribing opioids.

6           13. Respondent deviated from the standard of care by failing to establish the  
7 diagnosis and treatment plan prior to prescribing opioids.

8           14. The standard of care for prescribing opioids for chronic pain requires a  
9 physician to obtain appropriate consults from other physicians in pain medicine, neurology,  
10 psychiatry and/or psychology and physical therapy.

11           15. Respondent deviated from the standard of care by failing to obtain  
12 appropriate consults from other physicians.

13           16. The standard of care for prescribing opioids for chronic pain requires a  
14 physician to adjust medication doses to control the pain and non-pharmacological  
15 treatments such as injections and physical therapy are to be included in the overall  
16 management of the patient.

17           17. Respondent deviated from the standard of care by failing to adjust  
18 medication doses to control the pain and include non-pharmacological treatments such as  
19 injections and physical therapy in the overall management of the patient.

20           18. The standard of care for prescribing opioids requires a physician to perform  
21 random urine drug testing and pill counts to determine medication compliance.

22           19. Respondent deviated from the standard of care by failing to perform random  
23 urine drug screens and pill counts to determine SM's medication compliance.

24           20. SM is at risk for unnecessary and incorrect treatment as a result of the  
25 inappropriate prescribing practices.

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### **CONCLUSIONS OF LAW**

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1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

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2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

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3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.")

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### **ORDER**

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IT IS HEREBY ORDERED THAT:

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1. Respondent is issued a Letter of Reprimand.

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2. Respondent is placed on probation for ONE year with the following terms and conditions:

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Respondent shall within six months of the effective date of this Order complete the PACE prescribing course. Upon completion of the CME, Respondent shall provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license. The probation shall terminate upon successful completion of the CME.

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### **RIGHT TO PETITION FOR REHEARING OR REVIEW**

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Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after

24

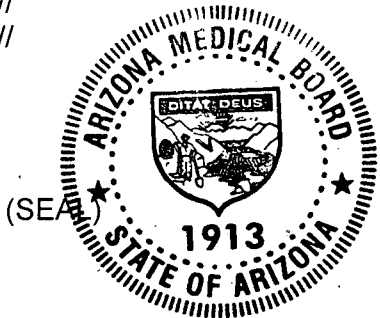
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1 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,  
2 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

3 Respondent is further notified that the filing of a motion for rehearing or review is  
4 required to preserve any rights of appeal to the Superior Court.

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6  
7 DATED AND EFFECTIVE this 11<sup>TH</sup> day of AUGUST, 2011.

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9 //  
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ARIZONA MEDICAL BOARD

By

  
Lisa S. Wynn  
Executive Director

17 EXECUTED COPY of the foregoing mailed  
this 11<sup>th</sup> day of August, 2011 to:

18 John Pellerito, MD  
19 Address of Record

20 ORIGINAL of the foregoing filed  
this 11<sup>th</sup> day of August, 2011 with:

21 Arizona Medical Board  
22 9545 E. Doubletree Ranch Road  
23 Scottsdale, AZ 85258

24   
25 Arizona Medical Board Staff

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**JOHN T. PELLERITO, M.D.**

Board Case No. MD-10-1255A

(Letter of Reprimand With Probation)

## ORDER

Respondent's Petition for Rehearing or Review is denied. The Board's August 11, 2011, Findings of Fact, Conclusions of Law and Order for Letter of Reprimand With Probation in Case no. MD-10-1255A is effective and constitutes the Board's final administrative order.

Respondent is hereby notified that he has exhausted his administrative remedies. Respondent is advised that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to title 12, chapter 7, article 6 of Arizona Revised Statutes.

1  
2 DATED this 17<sup>th</sup> day of October, 2011.

3  
4 THE ARIZONA MEDICAL BOARD



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11  
12  
13  
14 By Amala Biel  
LISA WYNN  
Executive Director

15 ORIGINAL of the foregoing filed this  
16 17<sup>th</sup> day of October, 2011 with:

17  
18 Arizona Medical Board  
19 9545 East Doubletree Ranch Road  
20 Scottsdale, Arizona 85258

21 Executed copy of the foregoing  
22 mailed by U.S. Mail this  
23 17<sup>th</sup> day of October, 2011 to:

24 John T. Pellerito, M.D.  
25 Address of Record